ATTACHMENT III
SYSTEM PERFORMANCE

1.0 LME

1.1 General Administration and Governance

1.1.1 Local Business Plan Implementation

Indicator: The LME implements and manages each required element of the Local Business Plan in a timely manner and modifies elements as needed to achieve goals.

Measurement:

The LME will submit a quarterly update report by the 30th of the month following the end of each quarter, showing that each of the required elements is being implemented, managed, and modified as needed. The report will contain a statement signed by the CFAC, indicating that the CFAC was given an opportunity to review and comment on the report and any plan modifications DHHS will evaluate the quarterly reports for evidence of operationalization, achievements and necessary modifications and give feedback to the LME within 30 days.

Best Practice and SFY2005 Performance Standard = 100% of reports are submitted on time, show evidence of plan implementation and contain a statement signed by the CFAC.

1.2 Access, Triage and Referral

1.2.1 Access to Emergent Care

Indicator: Persons in crisis have access to face-to-face emergency care within two hours after the request for care is initiated. Access is defined as having a qualified provider on the physical premises ready to provide immediate care as soon as the consumer is available to receive care.

Measurement:

Each LME will maintain a log for each telephonic request for service to address emergent needs that indicates: (1) the time of the request, (2) the time the determination is made that emergency care is needed, (3) the referral provider, and (4) the time that access to face to face emergency care is available. The LME will report quarterly the number of persons requesting service for emergent needs, the percent who are determined to need emergency care and, of those, the percent for whom access to face-to-face emergency care is available within two hours of the request for care. The DHHS will review a random sample of up to 20 emergent services annually to verify that the information submitted is accurate.

Best Practice Performance Standard = 100% of cases meet the time requirement.
SFY2005 Performance Standard = 85% of cases meet the time requirement.

1.2.2 Access to Urgent Care

Indicator: Eligible persons have their first face-to-face service to address urgent needs (assessment and/or treatment) within 48 hours of the request for care.

Measurement:

> Each LME will maintain a log for each request for service to address urgent needs that indicates: (1) the time of the request, (2) the time the determination is made that urgent care is needed, (3) the referral provider and (4) the time that face to face urgent care is initiated. The LME will report quarterly the number of persons requesting service for urgent needs, the percent that are determined to need urgent care, and, of those, the percent for which face-to-face urgent care is initiated within 48 hours of the request for care. DHHS will review a random sample of up to 20 urgent services annually to verify that the information submitted is accurate.

Best Practice Performance Standard = 100% of cases meet the time requirement.
SFY2005 Performance Standard = 85% of cases meet the time requirement.

1.2.3 Access to Routine Care

Indicator: Eligible persons have their first face-to-face medically appropriate service (assessment and/or treatment) within 7 calendar days of the date of the request for care.

Measurement:

> Each LME will maintain a log for each request for service to address non-crisis needs that indicates: (1) the time/date of the request, (2) the time/date the determination is made that routine care is needed, and (3) the referral provider. The LME will report quarterly the number of persons requesting service for non-crisis needs, the percent who are determined to need routine care, and, of those, the percent for whom face-to-face routine care is initiated within 7 calendar days of the request, based on IPRS data. DHHS will review a random sample of up to 20 routine services annually to verify that the information submitted is accurate.

Best Practice Performance Standard = 100% of cases meet the time requirement.
SFY2005 Performance Standard = 85% of cases meet the time requirement.

1.2.4 Access Line

Indicator: The LME maintains a toll-free Access line that is staffed 24 hours a day every day with live trained personnel.

Measurement:

> DHHS will determine the presence of the Access Line through a Mystery Shopper program that conducts a minimum of 10 calls per quarter.

Best Practice Performance Standard = 100% of calls are answered within 6 rings.
SFY2005 Performance Standard = 85% of calls are answered within 6 rings.

1.3 Service Management

1.3.1 Choice of Providers

Indicator: All eligible persons requesting service through the LME Access, Triage and Referral System or service authorization receive information to make an informed selection of service provider(s).

Measurement:

> The LME will develop a system by December 31, 2004 to ensure and allow DHHS to verify that all eligible persons who request service receive information to make an informed selection of service providers.

Best Practice Performance Standard = The system is operational by December 31, 2004.
SFY2005 Performance Standard = The system is developed and in place by December 31, 2004.

1.3.2 Discharge Planning with State Operated Facilities

Indicator: The LME communicates with the State-operated facility to collaborate around issues related to discharge planning and community care. The procedures for collaborative discharge planning from State-operated hospitals and ADATCs are in accordance with 10A NCAC 28F.0209. Nothing in this section will be construed as subjecting the LME to the requirements of the Civil Rights for Institutionalized Persons Act (CRIPA) or the jurisdiction of the US Department of Justice.

Measurement:

> The DHHS will review a random sample of records for up to 20 individuals who were discharged from State-operated facilities for evidence that the LME or agent was involved in the development of the discharge plan, where (1) the LME authorized the inpatient services and (2) the State-operated facility notified the LME of the intention to discharge.

Best Practice Performance Standard: 100% of cases reviewed show documentation of LME involvement in discharge planning.
SFY2005 Performance Standard: 85% of cases reviewed show documentation of LME involvement in discharge planning.

1.3.3 After-care Planning with State Operated Services

Indicator: The LME works with a consumer to determine the consumer's appropriate choice of provider and makes an appointment with the chosen provider for follow-up care within five (5) working days of discharge, after notification from a State-operated facility that a consumer will be discharged. If the consumer does not attend the appointment (i.e., no show), the LME documents that reasonable professional efforts were made to contact and reschedule care for the consumer. Reasonable effort is defined as documentation of at least one of the following within one week of the initial missed appointment: (1) a home visit or (2) a rescheduled office appointment that the individual keeps or (3) a phone conversation with the individual about the services being offered or (4) at least 3 attempts to contact the individual at his or her last known address.

Measurement:

DHHS will review a random sample of up to 20 provider records annually for persons discharged from State-operated facilities, where notice of the discharge was given to the LME.

Best Practice Performance Standard = 100% of the individuals for whom records are reviewed are seen by a provider of their choice within 5 working days of discharge, or meet criteria that all reasonable professional effort was made to see, or reschedule, any individuals who do not show up for the appointment.

SFY2005 Performance Standard = 85% of the individuals for whom records are reviewed are seen by a provider of their choice within 5 working days of discharge, or meet criteria that all reasonable professional effort was made to see, or reschedule, any individuals who do not show up for the appointment.

1.3.4 Compliance with Diversion Law (G.S. 122C-261(f)

Indicator: The LME grants an exception to the Diversion Law for admission to a State-operated psychiatric hospital for a consumer with mental retardation only when the consumer meets the exception criteria and efforts have been made to secure admission at three appropriate non-State facilities.

Measurement:

DHHS will review a random sample of up to 20 cases of persons with mental retardation admitted to State-operated psychiatric hospitals annually to verify that (1) the consumer met the exception criteria and (2) the LME contacted at least 3 appropriate facilities in an attempt to secure admission.

Best Practice Performance Standard = 100% of records reviewed meet the requirements.
SFY2005 Performance Standard = 85% of records reviewed meet the requirements.

1.3.5 Transition to Community Services

Indicator: In order to facilitate the community transition of consumers from State-operated facilities to community-based services, the LME provides community-based services to consumer groups previously served in State-operated facilities commensurate with available resources allocated by the DMH/DD/SAS and from those earned via billings to Medicaid.

Measurement 1:

The DHHS will approve and review implementation of the LME's community capacity plan.

Best Practice Performance Standard= 100% of services and supports are developed according to the timeline set forth in the LME's DHHS approved community capacity plan.

SFY2005 Performance Standard = 80% of services and supports are developed according to the timeline set forth in the LME's DHHS-approved community capacity plan

Measurement 2:

The DHHS will compare the LME's State Hospital and ADATC bed day utilization per category with established bed day allocations.

Best Practice Performance Standard = Utilization of 90% or less per category of bed day allocation.

SFY2005 Performance Standard = Utilization of 100% or less per category of bed day allocation. (NOTE: Utilization per category in excess of the established bed day allocations may result in a $500 per day charge, based on current policy.)

1.4 Provider Relations and Support

1.4.1 Proximity

Indicator: The LME ensures geographic access to supports and services. Geographic location of providers shows coverage of entire populated catchment area as specified in the Local Business Plan to provide crisis, assessment, case management, outpatient therapy, and periodic CAP-MR/DD waiver services.

Measurement:

The LME will submit an annual report with maps showing the location of providers who offer each listed service in relation to the location of the general population. DHHS will provide the LME with a map of the general population by zip code.

Best Practice Performance Standard = 95% of the general population are within the required distance of a provider of each listed service.
SFY2005 Performance Standard = 85% of the general population are within the required distance of a provider of each listed service

1.4.2 SB163 Provider Monitoring

Indicator: The LME develops policies and procedures in accordance with 10A NCAC 27G .0600 which address (a) receiving, reviewing and responding to Level II and III incident reports, (b) receiving and responding to complaints, (c) monitoring Category A and B providers of public services and (d) analyzing trends in the information from the above activities. The LME monitors providers in its catchment area according to S.L. 2002-164, 10A NCAC 27G .0600 and the LME policies and procedures.

Measurement:

The LME will submit monthly Provider Monitoring Reports summarizing monitoring activities. DHHS will review the LME's policies and procedures and analyze monthly monitoring reports for timeliness of correction of cited problems.

Best Practice Performance Standard = Policies and procedures are developed and implemented with all required elements. 100% of providers monitored complete corrections on time or are referred by the LME to DHHS in accordance with 10A NCAC 27G .0608(a)(2).
SFY2005 Performance Standard = Policies and procedures are developed and implemented with all required elements. 85% of providers monitored complete corrections on time or are referred by the LME to DHHS in accordance with 10A NCAC 27G .0608(a)(2).

1.5 Customer Services and Consumer Rights

1.5.1 Consumer Rights: Proper Notice

Indicator: The LME sends Medicaid-eligible consumers proper notice of all denials, suspensions, terminations, or reduction of services according to DHHS guidelines about due process for an appeal or hearing.

Measurement:

DHHS will review up to 20 cases for Medicaid-eligible persons who had services suspended, terminated or reduced to determine if the person received proper notice at least 10 working days prior to the termination, suspension or reduction of services in accordance with DHHS guidelines.

Best Practice Standard = 100% of cases reviewed indicate that the person received notice according to required timelines.
SFY2005 Performance Standard = 95% of cases reviewed indicate that the person received notice according to required timelines.

1.6 Quality Management and Outcomes Evaluation

1.6.1 Quality Improvement Process

Indicator: The LME uses its quality improvement process to improve the service delivery system.

Measurement:

The LME will submit an annual Quality Improvement report describing how it has used its quality improvement process to address service delivery system issues in at least one of the following areas: (a) building service capacity, (b) ensuring continuity of care during divestiture of services and/or (c) ensuring use of evidence-based practices. The DHHS will evaluate the report for inclusion of (1) the basis for choosing the issues targeted for improvement (e.g. data analyzed), (2) strategies developed to address identified issues, (3) actions taken, (4) an evaluation of results to date and (5) recommendations for next steps.

Best Practice Performance Standard = The report indicates that at least 5 QI projects that incorporate the 5 elements above were undertaken.
SFY2005 Performance Standard = The report indicates that at least 3 QI projects that incorporate at least 3 of the elements above were undertaken.

1.6.2 Incident Management

Indicator: LME reviews all Level II and III incidents reported by providers and takes action to prevent future incidents, as defined in 10A NCAC 27G .0600.

Measurement:

The DHHS will review a random sample of up to 20 cases where a Level II or III Incident Report was filed to determine if there was adequate response and follow-up, as defined in 10A NCAC 27G .0600.

Best Practice Performance Standard = 100% of cases reviewed indicate adequate response and follow-up.
SFY2005 Performance Standard = 85% of cases reviewed indicate adequate response and follow-up.

1.6.3 Incident Reporting

Indicator: LME analyzes Level II and III incidents reported by providers to determine trends and take action to make system improvements, as defined in 10A NCAC 27G .0600.

Measurement:

The LME will submit quarterly reports summarizing Level II and III incidents reported by providers. The report will include summaries of (1) data analyses to identify patterns and trends, (2) strategies developed to address problems, (3) actions taken, (4) the evaluation of results and (5) recommendations for next steps. DHHS will review the reports for evidence of an effective incident review process.

Best Practice Performance Standard = The 4 quarterly reports together show clear evidence of an effective process that contains all elements (1) through (5) above.
SFY2005 Performance Standard = 75% of reports (3 out of 4 quarters) that identify trends, contain plans, actions and results for how the LME is addressing those trends to make improvement in services.

1.7 Business Management and Accounting

1.7.1 Claims Adjudication

Indicator: The LME approves or denies service claims/provider invoices submitted within 60 days of service within 18 calendar days of receipt. The LME pays all clean claims/provider invoices billed to the LME within 60 days of service within thirty (30) calendar days after approval.

Measurement:

(1) DHHS will review a 1% sample of claims.
(2) DHHS will review provider complaints and grievances.

Best Practice Performance Standard = Ninety-five percent (95%) of clean claims are paid within thirty (30) calendar days after approval.
SFY2005 Performance Standard = 75% of clean claims are paid within thirty (30) calendar days after approval.

1.8 Information Management, Analysis and Reporting

1.8.1 System Monitoring

Indicator: The LME submits all required system monitoring reports in acceptable format by the due date as specified in the following table:

Report/Indicator	Measurement
Quarterly Fiscal Monitoring Reports	The LME submits Fiscal Monitoring Reports by the 20th day of the month following the end of the quarter. Reports are accurate and complete. Best Practice and SFY2005 Performance Standard = 100% of reports are accurate, complete and received by the due date
Cost-finding Report	The LME submits an annual cost finding for SFY2004 by November 15, 2004. The submission is accurate and complete. Best Practice and SFY2005 Performance Standard = The required report is accurate, complete and received by the due date

Report/Indicator	Measurement
Paybacks for non-compliance items identified during the Annual Medicaid Services Audit.	The LME will ensure that timely and complete paybacks are made within 90 days of notice. The DMH/DD/SAS will reconcile LME Payback Reports with DMA and review for timely payment. Best Practice Performance Standard = 100% of required paybacks are made within 60 days of notice from the DHHS. 2005 Performance Standard = 100% of required paybacks are made within 90 days of notice from the DHHS.
SAPTBG Compliance Report	The LME will submit semi-annual SAPTBG Compliance Reports by the 20th of the month following the end of the semi-annual period. Reports are accurate and complete and show at least 48 hours of Synar activity for the reporting period. Best Practice Performance Standard = 100% of reports are accurate and complete, received by the due date and show at least 48 hours of Synar activity for the reporting period. SFY2005 Performance Standard = 100% of reports are accurate and complete, received no later than 10 calendar days after the due date, and show at least 48 hours of Synar activity for the reporting period.
Substance Abuse/Juvenile Justice Initiative Quarterly Report	The LME will submit quarterly Substance Abuse/Juvenile Justice Initiative Reports by the 20th of the month following the end of the quarter. Reports are accurate and complete. Best Practice Performance Standard = 100% of reports are accurate, complete and received by the due date SFY2005 Performance Standard = 100% of reports are accurate, complete. 75% of reports are received on time, and 100% are received no later than 10 calendar days after the due date
Work First Initiative quarterly reports.	The LME will submit quarterly Work First Initiative Reports by the 20th of the month following the end of the quarter. Reports are accurate and complete. Best Practice Performance Standard = 100% of reports are accurate, complete and received by the due date SFY2005 Performance Standard = 100% of reports are accurate, complete. 75% of reports are received on time, and 100% are received no later than 10 calendar days after the due date

1.8.2 Consumer Information

Indicator: The LME collects and/or submits, as required, timely and complete client data reports for all clients as specified in the following table:

Data/Indicator	Measurement
Client Data Warehouse *The Client Data Warehouse (CDW) is the DHHS's source of information to monitor program, clinical and demographic information on the*	The LME will submit monthly consumer data by the 15th of each month. Submitted admission records (record type 11) are accurate. The LME will submit an annual Demographic update file for SFY2004 by August 15, 2004.

Data/Indicator	Measurement
consumers served. The data are also used to respond to Departmental, Legislative and Federal reporting requirements.	Best Practice Performance Standard = ▪ 90% of all required data fields are complete (1 quarter lag time) ▪ 90% of all mandatory and required data fields contain a value other than "unknown" (1 quarter lag time). ▪ 90% of the individuals served each quarter have Primary and Principal diagnoses (Lag time from the end of the quarter date to the admission date). ▪ 90% of Substance Abuse Principal and Primary diagnoses have Substance Abuse detail records (record 17 and 18) within 90 days of admission. SFY2005 Performance Standard = 10% less than Best Practice Standard on any indicator.
Consumer Functional Outcomes *Client Functional Outcomes data are the DHHS source of information to monitor the impact of services on persons receiving mh/dd/sa services. The data are also used to respond to Departmental, Legislative and Federal reporting requirements.* *The LME must have a sample of their clients regularly surveyed with outcomes instruments devised by DHHS following sampling rules and survey methodology. For FY2004-2005 this shall include participation in the Client Outcome Initiative (COI) and the NC Treatment Outcomes and Program Performance System (NCTOPPS) Assessments. During the year, the LME will transition all surveyed MH and SA clients ages six and older to one common web-based system (NC TOPPS). (NOTE: Consumers currently administered the DD-COIs and EI-COIs will be transitioned to the web-based system in sfy2006.)*	The LME, through providers, will collect outcomes information on its consumers following sampling methods and reporting schedules for the instrument being used. The appropriate outcomes instrument to use depends on the type of consumer and a transition schedule for the LME. 1. The EI COI is required for consumers up through five years of age whose case numbers end in 3 or 6 2. The DD COI is required for consumers with a primary disability of developmental disabilities ages 6 and older whose case numbers end in 3 or 6 3. The NC TOPPS is required for all consumers in specified substance abuse populations 4. The MH/SA COI is required for all other consumers with a primary disability of mental health and/or substance abuse whose case numbers end in 3 or 6 until transition to the web-based NC TOPPS system. A transition plan will be made for the LME to move new and existing consumers to the expanded NC TOPPS system at an agreed-upon time during the fiscal year. By the end of the fiscal year, all MH/SA clients ages six and older will be using the NC TOPPS system. *For NC TOPPS submissions* ▪ The LME, through providers, will submit NC TOPPS forms on all required consumers within the timeframes specified in the NC TOPPS Manual. The expected number of initial forms will be determined as the number of active consumers in IPRS in the relevant target populations. ▪ The LME will administer the 3-month update form between 76 and 104 days after the initial form and submit the update form by the last day of the month following the month it is due. The update form is complete and accurate. The DMH/DD/SAS will sample clients with initial forms administered

Data/Indicator	Measurement
	between September 2004 and February 2005 to determine the timeliness, completeness and accuracy of update forms. Best Practice Performance Standard = 100% of initial and update forms are received on time and all designated items are complete. SFY2005 Performance Standard = 90% of initial and update forms are received on time and 90% of the designated items are complete. *For COI submissions* The LME will submit COIs on all required consumers within the timeframes specified in the COI Manual. The expected number of initial forms will be determined as the number of active consumers in the CDW with case numbers ending in 3 or 6 (20% sample) minus the number of consumers who are administered the NC TOPPS. [NOTE: This requirement will apply to NC TOPPS data after the LME transitions to the web-based system.] Best Practice Performance Standard = 100% of the expected initial COIs are submitted within the timeframes specified in the COI manual. SFY2005 Performance Standard = submission of 90% of the expected initial COIs within timeframes specified in the COI manual.
National Core Indicators (NCI) *CSS data are the DHHS source of information to monitor the satisfaction persons receiving developmental disability services. The data are also used to respond to Departmental, Legislative and Federal reporting requirements.*	The LME, through providers, will submit a pre-survey and consent form for each person selected to participate in the NCI project within the specified timeframes. All submissions are accurate and complete. Best Practice Performance Standard = 100% of pre-surveys and consents are received by the due date. SFY2005 Performance Standard = 100% of pre-surveys and consents are received within 10 calendar days of the due date.
Consumer Satisfaction Survey (CSS) *CSS data are the DHHS source of information to monitor the satisfaction persons receiving mental health and substance abuse services. The data are also used to respond to Departmental, Legislative and Federal reporting requirements.*	The LME, through providers, will administer the DHHS Client Satisfaction Surveys, consistent with DHHS standards for 10% of its active mental health and substance abuse caseload and submits data received according to DHHS guidelines. Best Practice Performance Standard = 100% of expected surveys are completed as required and received by the due date. SFY2005 Performance Standard = 85% of expected surveys are completed as required and received within 10 calendar days of the due date.

Data/Indicator	Measurement
Olmstead Outcome Monitoring *Olmstead Outcomes data are the DHHS source of information to monitor the impact of transitioning individuals from State facilities to community settings. The data are also used to respond to Departmental, Legislative and Federal reporting requirements.*	The LME, through providers, will collect and submit to DMH/DD/SAS via the web outcomes data on all consumers transitioning from State facilities monthly for 6 months, then quarterly for 9 months (i.e. months #9, #12 , and #15)and then yearly thereafter starting at month #24. Best Practice Standard = 100% of forms are completed as required and received by the required date SFY2005 Performance Standard = 100% of forms are completed as required and received within 30 days of the required date
NC SNAP *NC SNAP data are the DHHS source of information on the service needs of individuals receiving developmental disability services. The data are also used to respond to Departmental, Legislative and Federal reporting requirements.*	The LME, through providers, will submit to DMH/DD/SAS by the 15th of each month a file containing current assessment forms for all consumers receiving developmental disability services Best Practice Performance Standard = Data transmissions are received by the 15th of each month and 100% of current assessments are no more than 15 months old SFY2005 Performance Standard = Data transmissions are received by the 30th of each month and 95% of current assessments are no more than 15 months old